OLR Bill Analysis

sSB 16

AN ACT CONCERNING STANDARDS FOR HEALTH CARE PROVIDER CONTRACTS.

SUMMARY:

This bill makes a variety of changes in the laws relating to contracts between health care providers and health insurers. The bill:

1. increases the time an insurer has to pay paper claims and decreases the time it has to pay electronic claims;

2. requires the insurance commissioner to develop procedures by which an insurer develops and maintains a provider network;

3. requires an insurer to adhere to nationally accepted provider network standards;

4. requires an insurer to pay for certain health care services for which a prior authorization was received; and

5. generally prohibits provider contracts from setting a dentist's charges for services that are not covered benefits.

EFFECTIVE DATE: January 1, 2012

§ 1 — CLAIM PAYMENT REQUIREMENTS

Current law requires health insurers to pay claims within 45 days of receiving them. This bill instead requires them to pay claims submitted (1) on paper within 60 days and (2) electronically within 15 days. By law, if the claim does not include all required information, the insurer must send written notice to the claimant requesting the information be sent within 30 days. Under current law, upon receiving the requested information, the insurer must pay the claim within 30 days. The bill retains the 30 day payment period for paper claims and reduces the payment period to 15 days for electronic claims.

By law, if an insurer fails to pay a claim on time, it must pay the claimant the amount of the claim plus 15% interest. This is in addition to any other penalties imposed by law. If the interest due is less than $1, the insurer must instead deposit the amount in a separate interest-bearing account. At the end of each calendar year, the insurer must donate the account funds to the UConn Health Center.

§ 2 — PROVIDER NETWORK PROCEDURES

The bill requires the insurance commissioner to establish procedures for insurers to use to (1) solicit licensed health care providers to participate in the insurers' provider networks and (2) maintain provider participation in the networks.

For purposes of this section, insurers include HMOs, fraternal benefit societies, hospital and medical service corporations, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or medical benefit plans in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services.

§ 3 — PROVIDER NETWORK ADEQUACY

The bill requires each insurer that contracts with licensed health care providers to maintain a provider network that conforms to the standards established by the National Committee for Quality Assurance's (NCQA's) Managed Behavioral Healthcare Organization Standards and Guidelines for quality management and improvement.

For purposes of this section, insurers include HMOs, managed care organizations, preferred provider networks, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or medical benefits plans.

NCQA is a nonprofit organization that accredits and certifies a wide range of health care organizations.

§ 4 — PRIOR AUTHORIZATIONS BY UTILIZATION REVIEW COMPANIES

By law, if utilization review companies grant prior or concurrent authorizations for admissions, services, procedures, or extensions of hospital stays, the companies cannot later reverse the authorizations. The bill prohibits the companies or insurers from refusing to pay for admissions, services, procedures, or extensions of stays that were provided in reliance on the prior authorizations.

For purposes of this section, insurers include HMOs, fraternal benefit societies, hospital or medical service corporations, or other entities responsible for paying claims.

§ 5 — PRIOR AUTHORIZATIONS BY INSURER

Under the bill, if insurers grant prior authorizations for admissions, services, procedures, or extensions of hospital stays, other than through utilization review companies, and they take place in reliance on the prior authorizations, then the insurers cannot later reverse the authorizations or refuse to pay for the admissions, services, procedures, or extensions of stays.

For purposes of this section, insurers include HMOs, fraternal benefit societies, hospital and medical service corporations, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or medical benefit plans in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services.

§ 6 — DENTIST CHARGES

Under the bill, a provider contract between an insurer and a licensed dentist cannot require the dentist to provide services or procedures at a set fee unless the services or procedures are covered benefits under the dental plan. This does not apply to a self-insured plan or collectively bargained agreement.

For purposes of this section, an insurer includes an HMO, fraternal benefit society, hospital or medical service corporation, or other entity that delivers, issues, renews, amends, or continues an individual or

group dental plan in Connecticut.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 11 Nay 9 (03/15/2011)